

August 20, 2007

Division of Services for People with Disabilities Provider Business Continuity and Disaster Preparedness Critical Information Sheet

Please Check Provider Services:

24 hr Res. ___ Day Supports ___ Supported Employment ___ Supported Living ___ 24-Respite ___

(The DSPD Provider Critical Information Sheet shall be forwarded electronically to the Division's Emergency Planner within 30 days of award of contract and annually thereafter by July 1st of each year. An updated document should be forwarded to the Division upon any major organizational changes.) **All Items of this Document Should Be Completed. The completed document should be emailed to Steve Wrigley, Division Emergency Manager, at swrigley@utah.gov**

EMERGENCY CONTACT INFORMATION

Provider Name:

Provider Main Office Address:

City: _____ **State:** _____

Main Office Telephone Number / Backup Number:

Out of State Emergency Contact Number:

The following person is our primary Emergency Crisis Manager and will serve as the company spokesperson in the event of an emergency.

Primary Emergency Contact:

Telephone Number:

Alternative Number / Cellular Number:

E-mail Address:

If the Emergency Crisis Manager is not available the persons below will succeed in management:

Secondary Emergency Contact:

Telephone Number:

Alternative / Cellular Number:

E-mail Address:

Third Emergency Contact:

Telephone Number:

Alternative / Cellular Number:

Email Address:

If our current main office location is not accessible we will operate from the alternative location listed below:

Business Name:

Address:

City: _____ **State:** _____

Telephone Number:

Provider Disaster Preparedness Critical Information Sheet Continued:

We have Satellite Offices in the following Counties / Cities:

Name of Office Emergency Manager:

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Address:

*

Telephone Number:

*

Alternative / Cellular Number:

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E-mail Address:

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Name of Office Emergency Manager:

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Address:

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Telephone Number:

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Alternative / Cellular Number:

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Email Address:

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Name of Office Emergency Manager:

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Address:

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Telephone Number:

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Alternative / Cellular Number:

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E-mail Address:

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Name of Office Emergency Manager:

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Address:

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Telephone Number:

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Alternative / Cellular Number:

*

Email Address:

*

(Copy and Paste More Office locations if necessary)

Provider Residential / Day Support Site Locations: (Not necessary for Supported Employment / Supported Living and 24-hour Respite locations)

Provider Site Address	Alternative Site Address	# of Consumers
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●		
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Provider Disaster Preparedness Critical Information Sheet Continued:

Do you have an established EMERGENCY PLANNING TEAM Yes ____ No ____

WE PLAN TO COORDINATE WITH THE FOLLOWING PRIVIATE, LOCAL AND STATE AGENCIES:

We have coordinated with the following individuals, organizations, and community / state agencies in the development of our emergency plan.

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COMMUNICATIONS

How will you communicate with the Division of Services for People with Disabilities regional office and/ or State Office? How will you communicate with your local emergency operations center? (May want to consider out of State emergency contact number as part of your plan.)

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In the event of a disaster we will communicate with employees in the following way:

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